Medicare Part C Plan Reporting Requirements
Technical Specifications Document
Contract Year 2017

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BACKGROUND AND INTRODUCTION

CMS has authority to establish reporting requirements for Medicare Advantage Organizations (MAOs) as described in 42CFR §422.516 (a). Pursuant to that authority, each MAO must have an effective procedure to develop, compile, evaluate, and report information to CMS in the time and manner that CMS requires. Additional regulatory support for the Medicare Part C Reporting Requirements is also found in the Final Rule entitled "Medicare Program; Revisions to the Medicare Advantage and Prescription Drug Program" (CMS 4131-F).

This document provides a description of the reporting sections,[1] reporting timeframes and deadlines, and specific data elements for each reporting section.

The technical specifications contained in this document should be used to develop a common understanding of the data, to assist organizations in preparing and submitting datasets, to ensure a high level of accuracy in the data reported to CMS, and to reduce the need for organizations to correct and resubmit data.

Each Part C Reporting Requirement reporting section of this document has the following information presented in a standardized way for ease of use:

A. Data element definitions - details for each data element reported to CMS.

B. Notes - additional clarifications to a reporting section derived from the responses to comments received under the OMB clearance process.

C. Reminder: **Underlined passages indicate updates and/or new information from the last version including draft versions.**

GENERAL INFORMATION

Organizations for which these specifications apply are required to collect these data. Reporting will vary depending on the plan type and reporting section. Most reporting sections will be reported annually.

Reporting Part C Data: The information here should be used (unless otherwise indicated, or instructed by CMS) for reporting from this point forward.

The following data elements listed directly below are considered proprietary, and CMS considers these as not subject to public disclosure under provisions of the Freedom of Information Act (FOIA):*

- Employer DBA and Legal Name, Employer Address, Employer Tax Identification Numbers (Employer Group Sponsors), Agent/Broker Name, and Beneficiary Name.

*Under FOIA, Plans may need to independently provide justification for protecting these data if a FOIA request is submitted.

[1] The term "measure" has been replaced with the term "reporting section" effective 2013.

In order to provide guidance to Part C Sponsors on the actual process of entering reporting requirements data into the Health Plan Management System, a separate Health Plan Management System (HPMS) Plan Reporting Module (PRM) User Guide may be found on the PRM start page.

Exclusions from Reporting

National PACE Plans and 1833 Cost Plans are excluded from reporting all Part C Reporting Requirements reporting sections.

Reporting Sections suspended
#1 *Benefit Utilization*

#2 *Procedure Frequency*
#3 *Serious Reportable Adverse Events*
#4 *Provider Network Adequacy*
 # 8 Private Fee for Service (PFFS) Plan Enrollment Verification Calls
#10 *Agent Compensation Structure*
#11 *Agent Training and Testing*;
#12 *Sponsor Oversight of Agents*

Reporting Sections requiring validation
#5 Organizations, Determinations & Reconsiderations

#6 Grievances
#13 Special Needs Plans

Note: All other Reporting Sections are for monitoring purposes only and do not have to be validated at this time.

Major Changes from CY 2016 Technical Specifications
#6 Organization Determinations and Reconsiderations has four new data elements:

- Was the case processed under the expedited timeframe? (Y/N)
- Case Type (Service or Payment)
- Status of treating provider (Contract or Non-Contract)
- Additional Information (optional)

#17 Payments to Providers has four new data elements:

- Total Risk-based payments not linked to quality (e.g. 3N in APM definitional framework).
- Total capitation payment not linked to quality (e.g. 4N in the APM definitional framework)
- Total Medicare Advantage contracted providers paid based risk-based payments not linked to quality (e.g. 3N in the APM definitional framework)
- Total Medicare Advantage contracted providers paid based on capitation with no link to quality (e.g. category 4N in the APM definitional framework).

Reporting Sections newly suspended

- Sponsor Oversight of Agents

- Private Fee-For-Service (PFFS) Plan Enrollment Verification Calls

Added Clarifications

- Special Needs Plans Care Management
- Mid-Year Network Changes
- Payments to Providers underwent additional text clarification

Timely Submission of Data

Data submissions are due by 11:59 p.m. Pacific time on the date of the reporting deadline. CMS expects that data are accurate on the date they are submitted. Data submitted after the given reporting period deadline shall be considered late and may not be incorporated within CMS data analyses and reporting. Only data reflecting a good faith effort by an organization to provide accurate responses to Part C reporting requirements will be counted as data submitted in a timely manner.

If a plan terminates before or at the end of its contract year (CY), it is not required to report and/or have its data validated for that CY.

Organizations failing to submit data, or submitting data late and/or inaccurately, will receive compliance notices from CMS.

Correction of Previously Submitted Data / Resubmission Requests

If previously submitted data are incorrect, Part C Sponsors should request the opportunity to correct and resubmit data. Corrections of previously submitted data are appropriate if they are due to an error made at the date of the original submission, or as otherwise indicated by CMS. Once a reporting deadline has passed, organizations that need to correct data must submit a formal request to resubmit data via the HPMS Plan Reporting Module. Resubmission requests may only be submitted after the original reporting deadline has expired. In order to accommodate data validation activities, data corrections may only be submitted until March 31st following the last quarter or end of year reporting deadline. CMS reserves the right to establish deadlines after which no further corrections may be submitted. Detailed instructions on resubmissions may be found on the starter page of the HPMS Plan Reporting Module User Guide.

Due Date Extension Requests

Generally speaking, CMS does not grant extensions to reporting deadlines, as these have been established and published well in advance. It is our expectation that organizations do their best with the information provided in the most current version of the Technical Specifications to prepare the data to be submitted in a timely fashion. Any assumptions that organizations may make in order to submit data timely should be fully documented and defensible under audit. CMS will consider appropriate "Resubmission Requests" through the Plan Reporting Module (PRM).

Periodic Updates to the Technical Specifications

If CMS, through questions raised by plans, clarifies the prior technical specifications for a data element, CMS requires that plans incorporate this change for the entire reporting period. CMS has established the following email address for the purpose of collecting all questions regarding the Part C Technical Specifications: **Partcplanreporting@cms.hhs.gov** should be aware that immediate responses to individual questions may not always be possible given the volume of email this box receives. CMS recommends that plans first refer to the current Medicare Part C Reporting Requirements Technical Specifications for answers or, when appropriate, contact the HPMS help desk: 1-800-220-2028 or email: hpms@cms.hhs.gov .

REPORTING REQUIREMENT REPORTING SECTIONS LIST

The following summary table provides an overview of the parameters around each of the current Part C Reporting Requirements reporting sections.

Reporting Section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
1. Benefit Utilization		Suspended		
2. Procedure Frequency		Suspended		
3. Serious Reportable Adverse Events		Suspended		
4. Provider Network Adequacy		Suspended		
5. Grievances (Revised)	Coordinated Care Plans (CCPs), Provider Fee-For-Service Plans (PFFS), 1876 Cost, Medicare-Medicaid Plans (MMPs), Medicare Savings Accounts (MSAs) (includes all 800 series plans), Employer/Union Direct Contract	1/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31 (reporting will include each quarter.)	First Monday of February in following year Validation Required
6. Organization Determinations/ Reconsiderations (Revised)	CCP, PFFS, 1876 Cost, MMP, MSA (includes all 800 series plans), Employer/Union Direct Contract	1/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31 (reporting will include each quarter.)	Last Monday of February in following year Validation required

Reporting Section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
7. Employer Group Plan Sponsors	CCP, PFFS, 1876 Cost, MSA (includes 800 series plans and any individual plans sold to employer groups), Employer/Union Direct Contract	1/year PBP	1/1 - 12/31	First Monday of February in following year
8. PFFS Plan Enrollment Verification Calls		Suspended		
9. PFFS Provider Payment Dispute Resolution Process	PFFS (includes all 800 series plans), Employer/Union Direct Contract	1/year PBP	1/1-12/31	Last Monday of February in following year
10. Agent Compensation Structure		Suspended		
11. Agent Training and Testing		Suspended		
12. Sponsor Oversight of Agents		Suspended		
13. Special Needs Plans (SNPs) Care Management	Local CCP, Regional CCP, RFB Local CCP with SNPs. Includes 800 series plans.	1/Year PBP	1/1-12/31	Last Monday of February in following year Validation required
14. Enrollment/Disenrollment	Only 1876 Cost Plans with no Part D.*	2/Year Contract	1/1-6/30 7/1-12/31	Last Monday of August and February
15. Rewards and	Local	1/Year	1/1-12/31	Last Monday of

Reporting Section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
Incentives Programs	Coordinated Care Plans (Local CCPs), Medicare Savings Accounts (MSAs), Provider Fee-For-Service Plans (PFFS), and Regional Coordinated Care Plans (Regional CCPs)	Contract		February in following year
16. Mid-Year Network Changes	Regional CCP, Local CCP, RFB Local CCP, PFFS, MSA, 1876 Cost	1/Year Contract	1/1-12/31	Last Monday of February in following year
17. Payments to Providers	Local CCP Regional CCP RFB Local CCP PFFS MMP**	1/Year Contract	1/1-12/31	Last Monday of February in following year

*MA-PDs and PDPs report under Part D. MSA excluded.

** MMPs should report for all APMs, not just Medicare MMPs.

REPORTING SECTIONS

1. BENEFIT UTILIZATION (SUSPENDED)

2. PROCEDURE FREQUENCY (SUSPENDED)

3. SERIOUS REPORTABLE ADVERSE EVENTS (SUSPENDED)

4. PROVIDER NETWORK ADEQUACY (SUSPENDED)

5. GRIEVANCES

Reporting Section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
5. Grievances	01 – Local CCP 02 – MSA 03 – Religious Fraternal Benefit(RFB PFFS) 04 – PFFS 05 – MMP 06 – 1876 Cost 11 – Regional CCP 14 – Employee Union Direct (ED)-PFFS 15 – RFB Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.	1/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31 (reporting will include each quarter)	First Monday of February in following year

The data elements to be reported under this reporting section are:

A. Number of Grievances - Total Grievances
B. Number of grievances in which timely notification was given – Total Grievances
C. Number of Grievances – Number of Expedited Grievances
D. Number of grievances in which timely notification was given – Number of Expedited Grievances
E. Number of grievances – Dismissed Grievances
F. Number of Grievances - Enrollment/Disenrollment Grievances
G. Number of grievances in which timely notification was given – Enrollment/Disenrollment Grievances
H. Number of Grievances - Plan Benefit Grievances
I. Number of grievances in which timely notification was given – Plan Benefit Grievances
J. Number of Grievances - Access Grievances
K. Number of grievances in which timely notification was given –Access Grievances
L. Number of Grievances - Marketing Grievances
M. Number of grievances in which timely notification was given – Marketing Grievances
N. Number of Grievances - Customer Service Grievances
O. Number of grievances in which timely notification was given – Customer Service Grievances
P. Number of Grievances – Organization / Determination / Reconsiderations Process Grievances
Q. Number of grievances in which timely notification was given – Organization / Determination /Reconsideration Process Grievances
R. Number of Grievances - Quality of Care Grievances
S. Number of grievances in which timely notification was given – Quality of Care Grievances
T. Number of Grievances - Grievances related to "CMS Issues"
U. Number of grievances in which timely notification was given – Grievances related to "CMS Issues"
V. Number of Grievances - Other Grievances
W. Number of grievances in which timely notification was given – Other Grievances

* Timely notification of grievances means the member was notified according to the following timelines:

- For standard grievances: no later than 30 calendar days after receipt of grievance.
- For standard grievances with an extension taken: no later than 44 calendar days after receipt of grievance.
- For expedited grievances: no later than 24 hours after receipt of grievance.

Notes

- This reporting section requires upload into HPMS.

- In cases where a purported representative files a grievance on behalf of a beneficiary without an Appointment of Representative (AOR) form, the timeliness calculation ("clock") starts upon receipt of the AOR form. This is a contrast to grievances filed by a beneficiary, in which cases the clock starts upon receipt of the grievance.

- Sponsors should generate these reports at the end of each quarter of the contract year and hold them for the annual submission.

- For an explanation of Medicare Part C Grievance Procedures, refer to CMS Regulations and Guidance: 42 CFR Part 422, Subpart M, and Chapter 13 of the Medicare Managed Care Manual, and the CMS website: Medicare Managed Care Appeals & Grievances. For an explanation of grievance procedures for MMPs, refer to the Demonstration-specific three-way contracts.

- CMS requires plans to use the 22 categories described in this section to report grievances to CMS (Elements A-W). For purposes of Reporting Section 5:

- A grievance is defined in Chapter 13 of the Medicare Managed Care Manual as "Any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee or their representative may make the complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame. In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care."

- For Part C reporting, grievances are defined as those **grievances completed (i.e., plan has notified enrollee of its decision) during the reporting period,** regardless of when the request was received; and include grievances filed by the enrollee or his or her representative.

- Contracts should validate that the total number of grievances should be the sum of the grievances by category.

- Grievances processed in an expedited manner would also be reported in a grievance category; sponsors should not double-count expedited grievances when verifying the number of total grievances has been reported correctly. Contracts should validate that the total number of timely notifications is equal to the sum of the total number of timely notifications for each category excluding expedited grievances.

The category, "Grievances Related to CMS Issues" involves grievances that primarily involve complaints concerning CMS' policies, processes, or operations; the grievance is not directed against the health plan or providers. The grievance category is meant to identify those grievances that are due to CMS issues, and are related to issues outside of the Plan's direct control. This same type of categorization is used in the Complaint Tracking Module (CTM) and allows CMS to exclude those grievances that are outside of the Plan's direct control, from the total number of grievances filed against the contract.

Reporting Inclusions:

Report:

- Only those grievances processed in accordance with the grievance procedures outlined in 42 CFR Part 422, Subpart M (i.e., Part C grievances). Please note that MMP grievances are also included for reporting under these technical specifications.

- Report grievances involving multiple issues under each applicable category.

- Report grievances if the member is ineligible on the date of the call to the plan but was eligible previously.

- Dismissals: CMS expects that dismissed grievances represent a very small percentage of total Part C grievances a plan receives. However, this element has been added to provide plans with a means to report grievances that are received but not processed by the plan because they do not meet the requirements for a valid grievance. Generally, a dismissal would occur when the procedure requirements for a valid grievance are not met and the plan is unable to cure the defect. For example, a grievance is received from a purported representative of the enrollee, but a properly executed appointment of representative form has not been filed and there is no other documentation to show that the individual is legally authorized to act on the enrollee's behalf and the plan is unable to obtain the required documentation in a reasonable amount of time and therefore, dismisses the grievance. See guidance set forth in section 10.4.1 of Chapter 13.

Reporting Exclusions:

Do not report:

- Enrollee complaints only made through the CMS Complaints Tracking Module (CTM). CTM complaints are addressed through a process that is separate and distinct from the plan's procedures for handling enrollee grievances. Therefore, plans should not report their CTM records to CMS as their grievance logs.

- Withdrawn grievances.

- Enrollee grievances processed in accordance with the grievance procedures described under 42 C.F.R., Part 423, Subpart M (i.e., Part D grievances).

Additional Guidance

- In cases where an extension is requested after the required decision making timeframe has elapsed, the plan is to report the decision as non-timely. For example, Plan receives grievance on 1/1/2016 at 04:00pm. An extension is requested at 1/31/2016 04:05pm. Plan completes investigation and provides notification on 2/5/2016 04:00pm (35 calendar days after receipt). This grievance is not considered timely for reporting as the decision was rendered more than 30 calendar days after receipt.

- If an enrollee files a grievance and then files a subsequent grievance on the same issue *prior to* the organization's decision or deadline for decision notification (whichever is earlier), then the issue is counted as one grievance.

- If an enrollee files a grievance and then files a subsequent grievance on the same issue *after* the organization's decision or deadline for decision notification (whichever is earlier), then the issue is counted as a separate grievance.

- If the enrollee files a grievance with a previous contract, but enrolls in a new contract before the grievance is resolved, the previous contract is still responsible for investigating, resolving and reporting the grievance.

- *For MA-PD contracts:* Include only grievances that apply to the Part C benefit. (If a clear distinction cannot be made for an MA-PD, cases are reported as Part C grievances.)

For additional details concerning Reporting Section 5 reporting requirements, see the Part C Reporting Module and Appendix 1: FAQs: Reporting Sections 5 & 6.

6. ORGANIZATION DETERMINATIONS/RECONSIDERATIONS

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
6. Organization Determinations/ Reconsiderations	01 – Local CCP 02 –MSA 03 – RFB PFFS 04 –PFFS 05 – MMP 06 – 1876 Cost 11 – Regional CCP 14 – ED-PFFS 15 – RFB Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.	1/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31 (reporting will include each quarter)	Last Monday of February in following year

Data elements for this reporting section are contained in Table 1.

There are four new data elements:

- Was the case processed under the expedited timeframe? (Y/N)
- Case Type (Service or Payment)
- Status of treating provider (Contract or Non-Contract)
- Additional Information (optional)

Table 1: Data Elements for Organization Determinations/Reconsiderations Reporting Section

Element Number	Data Elements for Organization Determinations/Reconsiderations
6.1	Total Number of Organization Determinations Made in Reporting Time Period Above
6.2	Of the Total Number of Organization Determinations in 6.1, Number Processed Timely
6.3	Number of Organization Determinations – Fully Favorable (Services)
6.4	Number of Organization Determinations – Fully Favorable (Claims)
6.5	Number of Organization Determinations – Partially Favorable (Services)
6.6	Number of Organization Determinations – Partially Favorable (Claims)
6.7	Number of Organization Determinations – Adverse (Services)
6.8	Number of Organization Determinations – Adverse (Claims)
6.9	Number of Requests for Organization Determinations - Withdrawn
6.10	Number of Requests for Organization Determinations - Dismissals
6.11	Total number of Reconsiderations Made in Reporting Time Period Above
6.12	Of the Total Number of Reconsiderations in 6.11, Number Processed Timely
6.13	Number of Reconsiderations – Fully Favorable (Services)
6.14	Number of Reconsiderations – Fully Favorable (Claims)
6.15	Number of Reconsiderations – Partially Favorable (Services)
6.16	Number of Reconsiderations – Partially Favorable (Claims)
6.17	Number of Reconsiderations – Adverse (Services)
6.18	Number of Reconsiderations – Adverse (Claims)
6.19	Number of Requests for Reconsiderations - Withdrawn
6.20	Number of Requests for Reconsiderations - Dismissals
6.21	Total number of reopened (revised) decisions, for any reason, in Time Period Above
	For each case that was reopened, the following information will be uploaded in a data file:
6.22	Contract Number
6.23	Plan ID
6.24	Case ID
6.25	Case level (Organization Determination or Reconsideration)
6.26	Date of original disposition
6.27	Original disposition (Fully Favorable; Partially Favorable or Adverse)
6.28	Was the case processed under the expedited timeframe? (Y/N)

Element Number	Data Elements for Organization Determinations/Reconsiderations
6.29	Case type (Service or Claim)
6.30	Status of treating provider (Contract, Non-contract)
6.31	Date case was reopened
6.32	Reason(s) for reopening (Clerical Error, Other Error, New and Material Evidence, Fraud or Similar Fault, or Other)
6.33	Additional Information (Optional)
6.34	Date of reopening disposition (revised decision)*
6.35	Reopening disposition (Fully Favorable; Partially Favorable, Adverse or Pending)

* The date of disposition is the date the required written notice of a revised decision was sent per 405.982.

Notes

This reporting section requires a data entry and file upload.

- Sponsors should generate these reports at the end of each quarter of the contract year and hold them for the annual submission.

- For an explanation of Part C organization determination, reconsideration, and reopenings procedures, refer to CMS regulations and guidance: 42 CFR Part 422, Subpart M, and Chapter 13 of the Medicare Managed Care Manual, and the CMS website: Medicare Managed Care Appeals & Grievances. For an explanation of organization determination and reconsideration procedures for MMPs, refer to the Demonstration-specific three-way contracts.

- All plan types listed in the table at the beginning of this section are required to report: organization determinations, reconsiderations and reopenings, as described in this guidance, regardless of whether the request was filed by an enrollee, the enrollee's representative, a physician or a non-contract provider who signed a Waiver of Liability.

- In cases where a purported representative files an appeal on behalf of a beneficiary without an Appointment of Representative (AOR) form, the timeliness calculation ("clock") starts upon receipt of the AOR form. This is a contrast to appeals filed by a beneficiary, in which case the clock starts upon receipt of the appeal.

For instances when the organization approves an initial request for an item or service (e.g., physical therapy services) and the organization approves a separate additional request to extend or continue coverage of the same item or service, include the decision to extend or continue coverage of the same item or service as another, separate, fully favorable organization determination.

- Plans are to report encounter data, whereby an encounter took place under a capitation arrangement, as an organization determination. That is, we want plans to report capitated providers' encounters in lieu of actual claims data. All encounter data should be reported as timely submissions.

- If the plan receives an Organization Determination or Reconsideration Request and issues a timely decision, however, the request is withdrawn, the plan would report the timely decision as well as the withdrawn request.

- If the plan receives an Organization Determination or Reconsideration Request and the request is withdrawn prior to a decision being issued, the plan would report the withdrawal only.

CMS requires plans to report organization determinations and reconsiderations requests submitted to the plan. For purposes of Reporting Section 6:

- **Organization determination** is a plan's response to a request for coverage (payment or provision) of an item or service – including auto-adjudicated claims, service authorizations which include prior-authorization (authorization that is issued prior to the services being rendered), concurrent authorization (authorization that is issued at the time the service is being rendered) and post-authorization (authorization that is issued after the services has already been provided) , and requests to continue previously authorized ongoing courses of treatment. It includes requests from both contract and non-contract providers.

- **Reconsideration** is a plan's review of an adverse or partially favorable organization determination.

- **Fully Favorable** decision means an item or service was covered in whole.

- **Partially Favorable** decision means an item or service was partially covered. For example, if a claim has multiple line items, some of which were paid and some of which were denied, it would be considered partially favorable. Also, if a pre-service request for 10 therapy services was processed, but only 5 were authorized, this would be considered partially favorable.

- **Adverse** decision means an item or service was denied in whole.

- **Withdrawn** organization determination or reconsideration is one that is, upon request, removed from the plan's review process. This category excludes appeals that are dismissed.

- **Dismissal** is an action taken by a Medicare health plan when an organization determination request or reconsideration request lacks required information or otherwise does not meet CMS requirements to be considered a valid request. For example, an individual requests a reconsideration on behalf of an enrollee, but a properly executed appointment of representative form has not been filed and there is no other documentation to show that the individual is legally authorized to act on the enrollee's behalf per the guidance set forth in section 10.4.1 of Chapter 13. The plan must follow Chapter guidance in addition to guidance provided in the September 10, 2013 HPMS memo regarding Part C Reconsideration Dismissal Procedures prior to issuing the dismissal.

If a provider (e.g., a physician) declines to provide a service an enrollee has requested or offers alternative service, the provider is making a treatment decision, not an organization determination on behalf of the plan. In this situation, if the enrollee disagrees with the provider's decision, and still wishes to obtain coverage of the service or item, the enrollee must contact the Medicare health plan to request an organization determination or the provider may request the organization determination on the enrollee's behalf.

Reporting Inclusion

Organization Determinations:

- All fully favorable payment (claims) and service-related organization determinations for contract and non-contract providers/suppliers.

- All partially favorable payment (claims) and service-related organization determination for contract and non-contract providers/suppliers.

- All adverse payment (claims) and service-related organization determinations for contract and non-contract providers/suppliers.

Reconsiderations:

- All fully favorable payment (claims) and service-related reconsideration determinations for contract and non-contract providers/suppliers.

- All partially favorable payment (claims) and service-related reconsideration determinations for contract and non-contract providers/suppliers.

- All adverse payment (claims) and service-related reconsideration determinations for contract and non-contract providers/suppliers.

Reopenings:

- All Fully Favorable, Partially Favorable, Adverse or Pending Reopenings of Organization Determinations and Reconsiderations, as described in the preceding sections.

Report

- **Completed organization determinations and reconsiderations** (i.e., plan has notified enrollee of its pre-service decision or adjudicated a claim) during the reporting period, regardless of when the request was received. Plans are to report organization determination or reconsideration where a substantive decision has been made, as described in this section and processed in accordance with the organization determination and reconsideration procedures described under 42 C.F.R. Part 422, Subpart M and Chapter 13 of the Medicare Managed Care Manual.

  All Part B drug claims processed and paid by the plan's PBM are reported as organization determinations or reconsiderations.

- **Claims with multiple line items** at the "summary level."

- A **request for payment** as a separate and distinct organization determination, even if a pre-service request for that same item or service was also processed.

- A denial of a Medicare request for coverage (payment or provision) of an item or service as either partially favorable or adverse, regardless of whether Medicaid payment or provision ultimately is provided, in whole or in part, for that item or service."

- Denials based on exhaustion of Medicare benefits.

- In caseswhere an **extension** is requested after the required decision making timeframe has elapsed, the plan is to report the decision as non-timely. For example, Plan receives standard pre-service reconsideration request on 1/1/2016 at 04:00pm. An extension is requested at 1/31/2016 04:05pm. Plan completes reconsideration and provides notification on 2/5/2016 04:00pm (35 calendar days after receipt). This reconsideration is not considered timely for reporting as the decision was rendered more than 30 calendar days after receipt.

- Dismissals

Do not report:

- Independent Review Entity (IRE) decisions.

- Reopenings requested or completed by the IRE, Administrative Law Judge (ALJ), and Appeals Council.

- Concurrent reviews during hospitalization.

- Concurrent review of Skilled Nursing Facility (SNF), Home Health Agency (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) care.

- Duplicate payment requests concerning the same service or item.

- Payment requests returned to a provider/supplier in which a substantive decision (fully favorable, partially favorable or adverse) has not been made– e.g., payment requests or forms are incomplete, invalid or do not meet the requirements for a Medicare claim (e.g., due to a clerical error).

- A Quality Improvement Organization (QIO) review of an individual's request to continue Medicare-covered

services (e.g., a SNF stay) and any related claims/requests to pay for continued coverage based on such QIO decision.

- If a service is covered only by the plan's Medicaid benefit, and never covered by the MA plan as a supplemental Medicare benefit.

- Enrollee complaints only made through the CMS Complaints Tracking Module (CTM).

NOTE: For purposes of this current reporting effort, plans are not required to distinguish between standard and expedited organization determinations or standard and expedited reconsiderations.

For additional details concerning the Reporting Section 6 reporting requirements, see Appendix 1: FAQs: Reporting Sections 5 & 6.

Reopenings (Organization Determinations and Redeterminations)

1. A **reopening** is a remedial action taken to change a final determination or decision even though the determination or decision may have been correct at the time it was made based on the evidence of record.
2. Refer to 42 CFR §422.616 and Chapter 13, section 130 of the Medicare Managed Care Manual for additional information and CMS requirements related to reopenings.
3. All reopened coverage determinations and redeterminations should be included.
4. For cases that are in a reopening status across multiple reporting periods, contracts should report those cases in each applicable reporting period. For example, if a plan reopened an organization determination in the first quarter of a given calendar year, and sent the notice of the revised decision on in the second quarter of the same calendar year that case should be reported as "pending" in the Q1 data file and then as resolved in Q2 (either Fully Favorable, Partially Favorable or Adverse).
5. If the IRE fully or partially overturns the plan's determination, the **case is not and must not be** reported as a reopening.

7. EMPLOYER GROUP PLAN SPONSORS

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
7. Employer Group Plan Sponsors	01 – Local CCP 02 – MSA 04 – PFFS 06 – 1876 Cost 11 – Regional CCP 14 – ED-PFFS Organizations should include all 800 series plans and any individual plans sold to employer groups. Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.	1/year PBP	1/1 - 12/31	First Monday of February in following year

Data elements reported under this reporting section are:

Element Number	Data Elements for Employer Group Plan Sponsors
7.1	Employer Legal Name
7.2	Employer DBA Name
7.3	Employer Federal Tax ID
7.4	Employer Address
7.5	Type of Group Sponsor (employer, union, trustees of a fund)
7.6	Organization Type (State Government, Local Government, Publicly Traded Organization, Privately Held Corporation, Non-Profit, Church Group, Other)
7.7	Type of Contract (insured, ASO, other)
7.8	Is this a calendar year plan? (Y (yes) or N (no))
7.9	If data element 7.8 is no, provide non-calendar year start date.
7.10	Current/Anticipated Enrollment

Notes

- All employer groups who have an arrangement in place with the Part C Organization for any portion of the reporting period should be included in the file upload, regardless of enrollment. In this case, plans **should use** the date they have an arrangement in place with the employer group to identify the reporting year.

- For employer groups maintaining multiple addresses with your organization, please report the address from which the employer manages the human resources/health benefits.

- Federal Tax ID is a required field in the file upload. Organizations should work with their employer groups to collect this information directly. Alternatively, there are several commercially available lookup services that may be used to locate this number.

- Data Element 7.7: Type of contract (insured, ASO, other) refers to the type of contract the organization holds with the employer group that binds you to offer benefits to their retirees.

- For Data Element 7.10: Current/Anticipated Enrollment the enrollment to be reported should be as of the last day of the reporting period and should include all enrollments from the particular employer group into the specific plan benefit package (PBP) noted. (If an employer group canceled mid-way through the reporting period, they would still appear on the listing but would show zero enrollments.)

- The employer organization type is based on *how* plan sponsors file their taxes.

For organizations that provide coverage to private market employer groups and which are subject to Mandatory Insurer Reporting (MIR) of Medicare Secondary Payer data, CMS permits these organizations to use the employer address and tax ID information submitted via the MIR to also satisfy CMS' Part C Reporting and Validation Requirements. This does not imply, however, that if the organization has already submitted this information to CMS for some other purpose, they do not have to resubmit it to us again for the purposes of the Part C reporting requirements.

8. PRIVATE FEE-FOR-SERVICE (PFFS) PLAN ENROLLMENT VERIFICATION CALLS - SUSPENDED

9. PFFS PROVIDER PAYMENT DISPUTE RESOLUTION PROCESS; MONITORING PURPOSES ONLY

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
9. PFFS Provider Payment Dispute Resolution Process	03 – RFB PFFS 04 – PFFS 14 – ED-PFFS	1/year PBP	1/1-12/31	Last Monday of February in following year

Data elements reported under this reporting section are:

Element Number	Data Elements for PFFS Provider Payment Dispute Resolution Process
9.1	Number of provider payment denials overturned in favor of provider upon appeal
9.2	Number of provider payment appeals
9.3	Number of provider payment appeals resolved in greater than 60 days

Notes

This reporting section requires direct data entry into HPMS.

This reporting section must be reported by all PFFS plans, regardless of whether or not they have a network attached.

This reporting requirement seeks to capture only provider payment disputes which include any decisions where there is a dispute that the payment amount made by the MA PFFS Plan to deemed providers is less than the payment amount that would have been paid under the MA PFFS Plan's terms and conditions, or the amount paid to non-contracted providers is less than would have been paid under original Medicare (including balance billing).

10. AGENT COMPENSATION STRUCTURE – SUSPENDED

11. AGENT TRAINING AND TESTING – SUSPENDED

12. SPONSOR OVERSIGHT OF AGENTS – SUSPENDED

13. SPECIAL NEEDS PLANS (SNP) CARE MANAGEMENT

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
13. SNPs Care Management	SNP PBPs under the following types: 01 – Local CCP 11 – Regional CCP 15 – RFB Local CCP Organizations should exclude 800 series plans if they are SNPs.	1/Year PBP	1/1-12/31	Last Monday of February in following year

Data elements reported under this reporting section are:

D.E No.	Data Element (D.E.)	Inclusions	Exclusions
13.1	Number of new enrollees due for an Initial Health Risk Assessment (HRA)	To be included as new enrollees due for an Initial HRA, enrollees must have an effective enrollment date that falls within this measurement year,* they must complete an initial HRA within 90 days of enrollment, or be continuously enrolled in the plan for at least 90 days without receiving an initial HRA.. The initial HRA is expected to be completed within 90 days (before or after) the effective date of enrollment. A member who disenrolls from one SNP and enrolls in another one is reported as eligible for an initial HRA any time during the period of 90 days before or after the effective enrollment date in the new SNP.	Enrollees who are continuously enrolled in a plan with a documented initial or reassessment HRA in the previous measurement year. New enrollees who disenroll from the plan prior to the effective enrollment date or within the first 90 days after the effective enrollment date if they did not complete an initial HRA prior to disenrolling. Enrollees who receive an

D.E No.	Data Element (D.E.)	Inclusions	Exclusions
			initial or reassessment HRA and remain continuously enrolled. under a MAO whose contract was part of a consolidation or merger under the same legal entity during the member's continuous enrollment, where the consolidated SNP is still under the same Model of Care (MOC) as the enrollee's previous SNP.
13.2	Number of enrollees eligible for an annual reassessment HRA	Report all enrollees in the same health plan: W h o w e r e c o n t i n u o u s l y e n r o l l	Enrollees for whom the initial HRA was completed within the current measurement year.

D.E No.	Data Element (D.E.)	Inclusions	Exclusions
		e d f o r a p e r i o d o f 3 6 5 d a y s o r m o r e a f t e r c o m	

D.E No.	Data Element (D.E.)	Inclusions	Exclusions
		pleting their last HRA, including initial HRA	

D.E No.	Data Element (D.E.)	Inclusions	Exclusions
		s c o n d u c t e d p r i o r t o t h e e f f e c t i v e e n r o l l m e n t	

D.E No.	Data Element (D.E.)	Inclusions	Exclusions
		date. (See **Notes** below.) Who were continuou	

D.E No.	Data Element (D.E.)	Inclusions	Exclusions
		s l y e n r o l l e d f o r a p e r i o d o f o v e r 3 6 5 d a y s a n	

D.E No.	Data Element (D.E.)	Inclusions	Exclusions
		d a r e o v e r d u e f o r a r e a s s e s s m e n t H R A . W h o w e r	

D.E No.	Data Element (D.E.)	Inclusions	Exclusions
		e c o n t i n u o u s l y e n r o l l e d f o r 3 6 5 d a y s o r m o r e ,	

D.E No.	Data Element (D.E.)	Inclusions	Exclusions
		and never completed an HRA. A member is con	

D.E No.	Data Element (D.E.)	Inclusions	Exclusions
		s i d e r e d e n r o l l e d f o r 3 6 5 d a y s i f t h e y a r e e n r	

D.E No.	Data Element (D.E.)	Inclusions	Exclusions
		o l l e d f r o m 1 / 1 / 1 7 t o 1 2 / 3 1 / 1 7 . W h o w e r e c o n t	

D.E No.	Data Element (D.E.)	Inclusions	Exclusions
		i n u o u s l y e n r o l l e d f o r m o r e t h a n 9 0 d a y s , b u t	

D.E No.	Data Element (D.E.)	Inclusions	Exclusions
		never completed an HRA.	
13.3	Number of initial HRAs performed on new enrollees	Initial HRAs performed on new enrollees (as defined above in data element 13.1) within 90 days before or after the effective date of enrollment. If the initial HRA is performed in the 90 days prior to the effective enrollment date, it is reported as an initial HRA in the reporting year in which the effective enrollment date falls.	
13.4	Number of initial HRA refusals	Initial HRAs not performed on new enrollees within 90 days (before or after) of the effective date of enrollment due to enrollee refusal and for which the SNP has documentation of enrollee refusal.	Initial HRAs not performed for which there is no documentation of enrollee refusal.
13.5	Number of initial HRAs not performed because SNP is unable to reach	Initial HRAs not performed on new enrollees within 90 days (before or after) of the effective date of enrollment due to the SNP being unable to reach new enrollees and for	Initial HRAs not performed where the SNP does not have documentation showing that the enrollee did not

D.E No.	Data Element (D.E.)	Inclusions	Exclusions
	new enrollees	which the SNP has documentation showing that the enrollee did not respond to the SNP's attempts to reach him/her. Documentation must show that a SNP representative made at least 3 "non-automated" phone calls and sent a follow-up letter in its attempts to reach the enrollee.	respond to the SNP's attempts to reach him/her.
13.6	Number of annual reassessments performed on enrollees eligible for a reassessment	Number of annual reassessments performed on enrollees eligible for a reassessment (during the measurement year as defined in element 13.2 above). This includes: Reassessments performed within 365 days of last HRA (initial or reassessment HRA) on eligible enrollees. It also includes "first time" assessments occurring within 365 days of initial enrollment on individuals continuously enrolled up to 365 days from enrollment date without having received an initial HRA. When an initial assessment is performed in the 90 days prior to the effective enrollment date, the first annual reassessment must completed no more than 365 days after the initial HRA.	
13.7	Number of annual reassessment refusals	Annual reassessments not performed due to enrollee refusal and for which the SNP has documentation of enrollee refusal.	Annual reassessments not performed for which there is no documentation of enrollee refusal.
13.8	Number of annual reassessments where SNP is unable to reach enrollee	Annual reassessments not performed due to the SNP's inability to reach enrollees and for which the SNP has documentation showing that the enrollee did not respond to the plan's attempts to reach him/her. Documentation must show that a SNP representative made at least 3 non-automated phone calls and sent a	Annual reassessments not performed for which the SNP does not have documentation showing that the enrollee did not respond to the SNP's attempts to reach him/her. Required documentation of SNP's attempts to

D.E No.	Data Element (D.E.)	Inclusions	Exclusions
		follow-up letter in its attempts to reach the enrollee.	contact the enrollee show that the SNP made at least 3 phone calls and sent a follow-up letter in its attempts to reach the enrollee.

* The "measurement year" is the same as the calendar year for this version of these technical specifications.

** If a new enrollee does not receive an initial HRA within 90 days of enrollment that enrollee's annual HRA is due to be completed within 365 days of enrollment. A new enrollee who receives an HRA within 90 days of enrollment is due to complete a reassessment HRA no more than 365 days after the initial HRA was completed.

Notes:

- This reporting section requires direct data entry into HPMS.

- For Part C reporting, there are never to be more than 365 days between Health Risk Assessments (HRAs) for enrollees in special needs plans. SNPs are required to conduct an initial HRA within 90 days before or after a beneficiary's effective enrollment date. Initial HRAs conducted prior to the effective enrollment date are counted as initial HRAs in the year in which the effective enrollment date falls. For example, an initial HRA performed on November 23, 2016 for an enrollee with an effective date of enrollment of January 1, 2017 would be counted as an initial HRA in 2017. A SNP should not perform, or report on, a HRA if the beneficiary is not yet determined to be eligible to enroll in the SNP.

- If there is no HRA occurring within 90 days (before or after) of the effective enrollment date, the SNP is to complete a HRA as soon as possible. In this case, the HRA would be considered a reassessment.

- Note that, if the initial HRA is not completed within 90 days before or after the effective enrollment date, the SNP will be deemed non-compliant with this requirement.

- All annual reassessment HRAs are due to occur within 365 days of the last HRA. Thus, when an initial HRA is performed in the 90 days prior to an effective enrollment date that falls in the beginning of a calendar year, in order to comply with the requirement to perform the annual reassessment within 365 days of the last assessment, the first annual reassessment will be due within the same measurement year as the initial HRA. Note that is such cases, a new enrollee who has remained enrolled in the SNP for 365 days after the date of the initial HRA, will be counted in both data elements 13.1 and 13.2 because he/she is a new enrollee (13.1) and an enrollee eligible for an annual reassessment (13.2).

(Example: The effective enrollment date is 1-1-2017 and the initial HRA was completed in November 2016. The annual reassessment will be due in November 2017. The initial HRA and the annual reassessment HRA will both be reported for 2017 and the enrollee will be counted as both a new enrollee and as an enrollee eligible for annual reassessment.)

- The plan must have documentation of any HRAs not performed based on enrollee refusal or the SNP's inability to reach the enrollee. The SNP must document in its internal records that the enrollee did not respond to at least 3 "non-automated" phone calls and a follow up letter, all soliciting participation in the HRA. Automated calls ("robo" or "blast" calls) as a means of soliciting enrollees' participation in completing an HRA are inappropriate and do not count toward the three phone call attempts. Further, phone call attempts must be made by a SNP representative so that when an enrollee is reached, it is possible to perform the HRA at that time, by phone. CMS can request SNP HRA refusal and/or unable to reach documentation at any time to determine health plan compliance with Part C reporting requirements.

- Only completed HRAs that comprise direct beneficiary and/or caregiver input will be considered valid for purposes of fulfilling the Part C reporting requirements. This means, for example, that HRAs completed only using claims and/or other administrative data, would not be acceptable. For data elements 13.3 and 13.6, CMS requires only completed assessments. This reporting section excludes cancelled enrollments.[2]

- For Dual Eligible SNPs (D-SNPs) only, CMS will accept a Medicaid HRA that is performed within 90 days before, or no more than 90 days after the effective date of Medicare enrollment as compliant with Part C reporting requirements.

- If an enrollee has multiple reassessments within the 90 day or the 365 day time periods, just report one HRA for the period in order to meet the reporting requirement. The count for the 365 day cycle period for the HRA begins with the day after the date the previous HRA was completed for the enrollee.

- If eligibility records received after completion of the HRA indicate the member was never enrolled in the plan, do not count this beneficiary as a new enrollee or count the HRA.

- The date the HRA is completed by the sponsoring organization is the completed date of the HRA.

- Questions have arisen regarding how to report data elements in this reporting section when enrollees disenroll and then re-enroll, either in the same SNP or a different one (different organization or sponsor) within the measurement year. When a member

[2] A cancelled enrollment is one that never becomes effective as in the following example:
An individual submits an enrollment request to enroll in Plan A on March 25th for an effective date of April 1st. Then, on March 30th, the individual contacts Plan A and submits a request to cancel the enrollment. Plan A cancels the enrollment request per our instructions in Chapter 2, and the enrollment never becomes effective."

disenrolls from one SNP and enrolls into another SNP (a different sponsor or organization), the member should be counted as a "new enrollee" for the receiving plan. Enrollees who received an initial HRA, and remain continuously enrolled under a MAO that was part of a consolidation or merger within the same MAO or parent organization will not need to participate in a second initial HRA.

- A HRA may be reported before an individualized care plan (ICP) is completed.

- Please note that these technical specifications pertain to Part C reporting only and are not a statement of policy relating to SNP care management.

14. ENROLLMENT AND DISENROLLMENT

Reporting section	Organization Types Required to Report*	Report Freq./ Level	Report Period (s)	Data Due date (s)
14. Enrollment and Disenrollment	All stand-alone MAOs (MA, no Part D) 1876 Cost Plans with no Part D	2/Year Contract	1/1-6/30 7/1 – 12/31	Last Monday of August and February

* For other organization types, please report this reporting section under the appropriate section in the Part D reporting requirements. For example, MA-PDs should report in Part D for this reporting section, listed as a "section" in Part D.

This reporting section requires data entry into HPMS

For Part C Reporting:

- All stand-alone MAOs (MA, no Part D) are to report this reporting section as well as 1876 cost plans with no Part D. For other organization types, please report this reporting section under the appropriate section in the Part D reporting requirements. For example, MA-PDs should report in Part D for this reporting section, listed as a "section" in Part D.

- CMS provides guidance for MAOs and Part D sponsors' processing of enrollment and disenrollment requests.

- Both Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Medicare Prescription Drug Benefit Manual outline the enrollment and disenrollment periods (Section 30) and enrollment (Section 40), disenrollment (Section 50) and reinstatement (Section 60) procedures for all Medicare health and prescription drug plans.

- CMS will collect data on the elements for these requirements, which are otherwise not available to CMS, in order to evaluate the sponsor's processing of enrollment, disenrollment and reinstatement requests in accordance with CMS requirements. For example, while there are a number of factors that result in an individual's eligibility for a Special Enrollment Period (SEP), sponsors are currently unable to specify each of these factors when submitting enrollment transactions. Sponsor's reporting of data regarding SEP reasons for which a code is not currently available will further assist CMS in ensuring sponsors are providing support to beneficiaries, while complying with CMS policies.

Section 1 Enrollment: Data elements 1.A-1.O must include all enrollments. Disenrollments must not be included in Section 1 Enrollment**.**

Note: For measurement year 2017, two data elements (M and N) were removed under Enrollment.

Section 2: Disenrollment must include all voluntary disenrollment transactions.

Reporting Timeline:

Reporting Period	January 1 – June 30	July 1-December 31
Data Due to CMS	Last Monday of August	Last Monday of February

Data elements to be entered into the HPMS at the Contract level.

Removed: For measurement year 2017, two data elements (M and N) were removed under Enrollment.

1. **Enrollment:**

A. The total number of enrollment requests (i.e., requests initiated by the beneficiary or his/her authorized representative) received in the specified time period. Do not include auto/facilitated or passive enrollments, rollover transactions, or other enrollments effectuated by CMS.

B. Of the total reported in A, the number of enrollment requests complete at the time of initial receipt (i.e. required no additional information from applicant or his/her authorized representative).

C. Of the total reported in A, the number of enrollment requests for which the sponsor was required to request additional information from the applicant (or his/her representative).

D. Of the total reported in A, the number of enrollment requests denied due to the sponsor's determination of the applicant's ineligibility to elect the plan (i.e. individual not eligible for an election period).

E. Of the total reported in C, the number of incomplete enrollment requests received that are incomplete upon initial receipt and completed within established timeframes.

F. Of the total reported in C, the number of enrollment requests denied due to the applicant or his/her authorized representative not providing information to complete the enrollment request within established timeframes.

G. Of the total reported in A, the number of paper enrollment requests received.

H. Of the total reported in A, the number of telephonic enrollment requests received (if sponsor offers this mechanism).

I. Of the total reported in A, the number of internet enrollment requests received via plan or affiliated third-party website (if sponsor offers this mechanism).

J. Of the total reported in A, the number of Medicare Online Enrollment Center (OEC) enrollment requests received.

K. Of the total reported in A, the number of enrollment requests effectuated by sales persons (as defined in Chapter 3 of the Medicare Managed Care Manual).

L. Of the total reported in A, the number of enrollment transactions submitted using the SEP Election Period code "S" related to creditable coverage.

~~M.~~

~~N.~~

O. Of the total reported in A, the number of enrollment transactions submitted using the SEP Election Period Code "S" for individuals affected by a contract nonrenewal, plan termination, or service area reduction.

2. Disenrollment:

A. The total number of voluntary disenrollment requests received in the specified time period. Do not include disenrollments resulting from an individual's enrollment in another plan.
B. Of the total reported in A, the number of disenrollment requests complete at the time of initial receipt (i.e. required no additional information from enrollee or his/her authorized representative).
C. Of the total reported in A, the number of disenrollment requests denied by the Sponsor for any reason.
D. The total number of involuntary disenrollments for failure to pay plan premium in the specified time period.
E. Of the total reported in D, the number of disenrolled individuals who submitted a timely request for reinstatement for Good Cause
F. Of the total reported in E, the number of favorable Good Cause determinations.
G. Of the total reported in F, the number of individuals reinstated.

15. REWARDS AND INCENTIVES PROGRAMS

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
15. Rewards and Incentives Programs	01 – Local CCP 02 – MSA 03 – RFB PFFS 04 – PFFS 05 – MMP 11 – Regional CCP 14 – ED-PFFS 15 – RFB Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.	1/Year Contract	1/1-12/31	Last Monday of February in following year

The data collection method is partially a data entry and an upload.

A plan user needs to select "Yes" or "No" for data element 15.1 on the edit page. If the plan user selected "No", no upload is necessary. If the plan user select "Yes", then the user will be required to upload additional information in accordance with the file record layout.

In 2015, CMS added a new regulation at 42 CFR §422.134 that permits MA organizations to offer one or more Rewards and Incentives Program (s) to currently enrolled enrollees. Plans have a choice in whether or not they offer a Rewards and Incentives Program(s), but if they do, they must comply with the regulatory requirements set forth at §422.134. CMS needs to collect Rewards and Incentives Program data in order to track which MA organizations are offering such programs and how those programs are structured. This will inform future policy development and allow CMS to determine whether programs being offered adhere to CMS standards and have proper beneficiary protections in place.

Data Elements:

15.1 Do you have a Rewards and Incentives Program(s)? (“Yes“ or “No” only;)

If yes, please list each individual Rewards and Incentives Program you offer and provide information on the following:

15.2 What health related services and/or activities are included in the program? [Text]

15.3 What reward(s) may enrollees earn for participation? [Text]

15.4 How do you calculate the value of the reward? [Text]

15.5 How do you track enrollee participation in the program? [Text]

15.6 How many enrollees are currently enrolled in the program? Enter _ _ _ _ _ _ _

15.7 How many rewards have been awarded so far? Enter _ _ _ _

16. MID-YEAR NETWORK CHANGES

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
16. Mid-Year Network Changes	01 – Local CCP 02 – MSA* 04 – PFFS* 06 – 1876 Cost 11 – Regional CCP** 15 – RFB Local CCP	1/Year Contract	1/1-12/31	Last Monday of February in following year

*Only network-based MSA and PFFS plans are required to report.
**Regional Preferred Provider Organizations (RPPOs) should only report on the network areas of their plans (not the non-network areas).

This reporting section requires a file upload into HPMS.

CMS is increasing its oversight and management of organizations' network changes in order to ensure that changes made during the contract year do not result in inadequate access to care for enrollees. The data collected in this measure will provide CMS with a better understanding of how often organizations undergo mid-year network changes and how many enrollees are affected. In addition, the data will enhance CMS's ability to improve its policy and process surrounding significant network changes (see section 110.1.2 of chapter 4 of the Medicare Managed Care Manual for more information).

CMS considers a mid-year network change to be any change in network (i.e., provider termination) that is not effective January 1 of a given year (the first day of the reporting period). In the following, we are asking organizations to report on mid-year terminations of primary care physicians (PCPs), certain specialists (cardiologists, endocrinologists, oncologists, ophthalmologists, pulmonologists, rheumatologists, urologists), and facilities (acute inpatient hospitals and skilled nursing facilities) during the reporting period. Organizations are to report on both for-cause and no-cause terminations, as well as both organization-initiated and provider-initiated terminations.[3]

An affected enrollee is an enrollee who was assigned to or received care from a reported terminated PCP, specialist, or facility within 90 days prior to the PCP/specialist/facility contract termination date. To maintain consistency in reporting, we are using the definition of PCP used in the current Health Service Delivery (HSD) Reference File, which can be found on the Medicare Advantage (MA) Applications website. In addition, the specialist and facility data we

[3] Note: Organizations are to report on terminations of contracts between the organization and the provider(s), such that affected enrollees are no longer able to see the provider(s) in-network. For example, if a PCP terminates its contract with a certain medical group and then joins a different medical group that is also contracted with the organization, but the enrollees assigned to that PCP are still able to see him/her continuously with no disruption, then this type of termination would *not* be counted.

are collecting aligns with some of the provider and facility specialty types that organizations are required to include in their networks and to submit on their HSD tables with an MA application or in the Network Management Module in HPMS.

Legal Basis:

All organizations, including MA organizations offering coordinated care plans, network-based private fee-for-service plans, and network-based medical savings account plans, as well as section 1876 cost organizations, must ensure access to essential services, in accordance with 42 CFR 417.414, 42 CFR 417.416, 42 CFR 422.112(a)(1)(i) and 42 CFR 422.114(a)(3)(ii). Therefore, these organization types must provide enrollees healthcare services through a contracted network of providers that is consistent with the pattern of care in the network service area (42 CFR 422.112(a)).

Data Elements (at the contract level):

Element Number	Data Elements for Mid-Year Network Changes Measure
16.1	Total number of PCPs in network on first day of reporting period, including the following PCP types - General Practice, Family Practice, Internal Medicine, Geriatrics, Primary Care-Physician Assistants, Primary Care-Nurse Practitioners
16.2	Total number of PCPs in network terminated during reporting period, including the following PCP types - General Practice, Family Practice, Internal Medicine, Geriatrics, Primary Care-Physician Assistants, Primary Care-Nurse Practitioners
16.3	Total number of PCPs added to network during reporting period, including the following PCP types - General Practice, Family Practice, Internal Medicine, Geriatrics, Primary Care-Physician Assistants, Primary Care-Nurse Practitioners
16.4	Total number of PCPs in network on last day of reporting period, including the following PCP types - General Practice, Family Practice, Internal Medicine, Geriatrics, Primary Care-Physician Assistants, Primary Care-Nurse Practitioners
16.5-16.13	Number of specialists/facilities in network on first day of reporting period by specialist/facility type - Cardiologist (16.5), Endocrinologist (16.6), Oncologist (16.7), Ophthalmologist (16.8), Pulmonologist (16.9), Rheumatologist (16.10), Urologist (16.11), Acute Inpatient Hospitals (16.12), Skilled Nursing Facilities (16.13)
16.14-16.22	Number of specialists/facilities in network terminated during reporting period by specialist/facility type - Cardiologist (16.14), Endocrinologist (16.15), Oncologist (16.16), Ophthalmologist (16.17), Pulmonologist (16.18), Rheumatologist (16.19), Urologist (16.20), Acute Inpatient Hospitals (16.21), Skilled Nursing Facilities (16.22)
16.23-16.31	Number of specialists/facilities added to network during reporting period by specialist/facility type - Cardiologist (16.23),

Element Number	Data Elements for Mid-Year Network Changes Measure
	Endocrinologist (16.24), Oncologist (16.25), Ophthalmologist (16.26), Pulmonologist (16.27), Rheumatologist (16.28), Urologist (16.29), Acute Inpatient Hospitals (16.30), Skilled Nursing Facilities (16.31)
16.32-16.40	Number of specialists in network on last day of reporting period by specialist/facility type - Cardiologist (16.32), Endocrinologist (16.33), Oncologist (16.34), Ophthalmologist (16.35), Pulmonologist (16.36), Rheumatologist (16.37), Urologist (16.38), Acute Inpatient Hospitals (16.39), Skilled Nursing Facilities (16.40)
16.41	Total number of enrollees on first day of reporting period
16.42	Total number of enrollees affected by termination of PCPs during reporting period
16.43-16.51	Total number of enrollees affected by termination of specialists/facilities by specialist/facility type during reporting period- Cardiologist (16.43), Endocrinologist (16.44), Oncologist (16.45), Ophthalmologist (16.46), Pulmonologist (16.47), Rheumatologist (16.48), Urologist (16.49), Acute Inpatient Hospitals (16.50), Skilled Nursing Facilities (16.51)
16.52	Total number of enrollees on last day of reporting period

17. PAYMENTS TO PROVIDERS

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
17. Payments to Providers	01 – Local CCP 11 – Regional CCP 15 – RFB Local CCP 04 – PFFS 05 – MMP*	1/Year Contract	1/1-12/31	Last Monday of February in following year

* MMPs should report for all APMs, not just Medicare MMPs.

This reporting section requires a file upload.

Based on internal review, we are adding four data elements (shown immediately below, and in table) in order to more accurately categorize existing MA payment arrangements. Categories 2, 3 and 4 of value based payment are inherently linked to quality as defined in the HHS developed Alternative Payment Model (APM) Definitional Framework. However, CMS recognizes that some providers are paid based on pure risk based or pure capitation models with no link to quality (e.g. 3N and 4N in the APM definitional framework), which are not specified under the current reporting data elements. The addition of the four proposed elements would allow more accurate reporting about the full spectrum and prevalence of alternative payment models in Medicare Advantage.

Collecting these data will help to inform us as we determine how broadly MA organizations are using alternative payment arrangements.

Four new data elements:

- Total Risk-based payments not linked to quality (e.g. 3N in APM definitional framework).
- Total capitation payment not linked to quality (e.g. 4N in the APM definitional framework)
- Total Medicare Advantage contracted providers paid based risk-based payments not linked to quality (e.g. 3N in the APM definitional framework)
- Total Medicare Advantage contracted providers paid based on capitation with no link to quality (e.g. category 4N in the APM definitional framework).

In order to maintain consistency with HHS goals of increasing the proportion of Medicare payments made based on quality and value, HHS developed the four categories of value based payment: fee-for-service with no link to quality (category 1); fee-for-service with a link to quality (category 2); alternative payment models built on fee-for-service architecture (category 3); and population-based payment (category 4). CMS will collect data from MA organizations

about the proportion of their payments made to contracted providers based on these four categories in order to understand the extent and use of alternate payment models in the MA industry. Descriptions of the four categories are as follows:

- Category one (1) includes a fee-for-service with no link to quality arrangement to include all arrangements where payments are based on volume of services and not linked to quality of efficiency.

- Category two (2) includes fee-for-service with a link to quality to include all arrangements where at least a portion of payments vary based on the quality or efficiency of health care delivery including hospital value-based purchasing and physician value-based modifiers.

- Category three (3) includes alternative payment models built on fee-for-service architecture to include all arrangements where some payment is linked to the effective management of a population or an episode of care. Payments are still triggered by delivery of services, but there are opportunities for shared savings or 2-sided risk.

- Category four (4) includes population-based payment arrangements to include some payment is not directly triggered by service delivery so volume is not linked to payment. Under these arrangements, clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., greater than a year).

For detailed information regarding these categories, please refer to the Alternative Payment Model (APM) Framework at https://hcp-lan.org/workproducts/apm-whitepaper.pdf

Data Elements (at the contract level):

Element Number	Data Elements for Payments to Provider
17.1	Total Medicare Advantage payment made to contracted providers.
17.2	Total Medicare Advantage payment made on a fee-for-service basis with no link to quality (category 1).
17.3	Total Medicare Advantage payment made on a fee-for-service basis with a link to quality (category 2).
17.4a	Total Medicare Advantage payment made using alternative payment models built on fee-for-service architecture (category 3)
17.4b	Total Risk-based payments not linked to quality (e.g. 3N in APM definitional framework)
17.5a	Total Medicare Advantage payment made using population-based payment (category 4).
17.5b	Total capitation payment not linked to quality (e.g. 4N in the APM definitional framework)

Element Number	Data Elements for Payments to Provider
17.6	Total number of Medicare Advantage contracted providers.
17.7	Total Medicare Advantage contracted providers paid on a fee-for-service basis with no link to quality (category 1).
17.8	Total Medicare Advantage contracted providers paid on a fee-for-service basis with a link to quality (category 2).
17.9a	Total Medicare Advantage contracted providers paid based on alternative payment models built on a fee-for-service architecture (category 3).
17.9b	Total Medicare Advantage contracted providers paid based risk-based payments not linked to quality (e.g. 3N in the APM definitional framework)
17.10a	Total Medicare Advantage contracted providers paid based on population based payment (category 4).
17.10b	Total Medicare Advantage contracted providers paid based on capitation with no link to quality (e.g. category 4N in the APM definitional framework).

APPENDIX 1: FAQS: REPORTING SECTIONS 5 & 6:

Grievances, Organization Determinations, & Reconsiderations

	PLAN INQUIRIES	CMS RESPONSES
1.	Should plans report informal complaints as Grievances under the Part C reporting requirements? For example, During the course of a home visit, a member expresses dissatisfaction regarding a particular issue. The member does not contact the plan directly to file a complaint, but the plan representative determines the member is not happy and logs the issue for Quality Improvement tracking.	Plans are to report any grievances filed directly with the plan and processed in accordance with the plan grievance procedures outlined under 42 CFR Part 422, Subpart M. Plans are not to report complaints made to providers, such as the complaint in the example provided, that are not filed with the plan.
3.	Should plans report **all** Dual Eligible member grievances to CMS?	No. Plans are only to report Dual Eligible member grievances processed in accordance with the grievance procedures outlined under 42 CFR Part 422, Subpart M. For example, grievances filed under the state Medicaid process but not filed with the plan and addressed under the plan's Subpart M grievance process, should not be reported."
4.	Is a plan to report a grievance, organization determination or reconsideration to CMS when the plan makes the final decision or when the request is received?	Plans are to report grievances, organization determinations and reconsiderations that were completed (i.e., plan has notified enrollee of its decision or provided or paid for a service, if applicable) during the reporting period, regardless of when the request was received.

5.	Are plans to report only those organization determinations defined under 42 C.F.R. 422.566?	CMS requires plans to report requests for payment and services, as described in the Part C Technical Specifications, Reporting section 6. Plans are to report requests for payment and services consistent with CMS regulations at 42 C.F.R. Part 422, Subpart M as "organization determinations." For example, plans are to include adjudicated claims in the reportable data for Organization Determinations.
6.	We are seeking information on how we should report pre-service requests and claims requests for this category. Do you want fully favorable, partially favorable, and adverse for both pre-service requests and claims requests?	Yes. Plans are to report fully favorable, partially favorable, and adverse pre-service and claims requests (organization determinations and reconsiderations), as described in this guidance
7.	If we have a prior authorization request and a claim for the same service -- is that considered a duplicate or should we report both?	Plans are to report **both** a prior authorization request and a claim for the same service; this is not considered a duplicate.
8.	Is a request for a predetermination to be counted as an organization determination? Does it matter who requests the predetermination – contracted provider, non-contracted provider or member? If so, should they also be counted as partially and fully unfavorable?	Organization determinations include a request for a pre-service ("predetermination") decision submitted to the plan, regardless of who makes the pre-service request – e.g., a contracted provider, non-contracted provider or member. Plans are to report partially favorable, adverse and fully favorable pre-service organization determinations, as described in this guidance.
9.	Should plans report determinations made by delegated entities or only decisions that are made directly by the plan – e.g., should plans report decisions made by contracted radiology or dental groups?	Yes. Plans are to report decisions made by delegated entities – such as an external, contracted entity responsible for organization determinations (e.g., claims processing and pre-service decisions) or reconsiderations.

10.	The Tech Specs advise plans to exclude certain duplicate/edits when reporting on the claim denial requirement. Is the intent to exclude duplicates or is it to exclude "billing" errors or both? For example, if a claim is denied because the provider didn't submit the claim with the required modifier, should that be excluded from the count?	Plans should exclude duplicate claim submissions (e.g., a request for payment concerning the same service) and claims returned to a provider/supplier due to error (e.g., claim submissions or forms that are incomplete, invalid or do not meet the requirements for a Medicare claim).
11.	Do we have to include lab claims for this reporting section? Do we need to report the ones which involve no pre-service as well as the ones that involve pre-service?	Yes. Plans are to report lab claims. Even in the absence of a pre-service request, a request for payment (claim) is a reportable organization determination.
12.	Enrollee is hospitalized for heart surgery, no prior authorization is required and the claim is paid timely in accordance with full benefit coverage. Our reading of the Medicare Managed Care Manual reveals that the organization is only required to notify the enrollee of Partially Favorable or Adverse decisions. There is no requirement to notify enrollees of Fully Favorable decisions. Is this an organization determination?	Prior authorization is not required to consider a decision an organization determination. A submitted claim is a request for an organization determination. All paid claims are reportable (fully favorable) organization determinations. Timeframe and notification requirements for Fully Favorable determinations are described under 42 C.F.R 422.568(b) and (c). *Written* notice is required for Partially Favorable, and Adverse determinations.
13.	Enrollee obtains a rhinoplasty for purely cosmetic reasons, which is a clear exclusion on the policy. Enrollee and provider both know this is likely not covered but they submit the claim. Claim is denied as an exclusion/ non-covered service. Neither the enrollee nor the provider pursues it any further. Is this an organization determination?	The plan is to report this denial as an organization determination. A request for payment (claim) is a reportable organization determination.
14.	Enrollee is out of area and in need of urgent care. Provider is out of area / network. The enrollee calls plan and requests a coverage determination for this service. Health Plan approves use of out of area services. Claim is submitted and paid in full. Is this counted as one event (i.e., pre-auth and claim not counted as two events)?	In this example, both the pre-service decision and claim are counted as two, separate fully favorable organization determinations. A claim submitted for payment is an organization determination request. Claims paid in full are reportable (fully favorable) organization determinations.
15.	When an organization determination is extended	Yes. Plans generally are to count an

	into the future does that extension count in the reporting of org determinations (e.g. on-going approval for services approved in the initial decision)?	initial request for an organization determination (request for an ongoing course of treatment) as separate from any additional requests to extend the coverage. For example, plans are to count an initial approved request for physical therapy services as one organization determination. If the plan, later, approves a subsequent request to continue the ongoing services, the plan should count the decision to extend physical therapy services as another, separate organization determination.
16.	Our interpretation is that the term "contracted provider" means "contracted with the health plan" not "contracted with Medicare".	Yes. For purposes of Part C Reporting Section 6 reporting requirements, "contracted provider" means "contracted with the health plan" not "contracted" (or participating) with Medicare."
17.	When we make an adverse determination that is sent to the QIO for review and later our adverse determination is overturned, should we count and report the initial Adverse determination that goes to the QIO? We understand that QIO determinations are excluded from our reporting.	Yes. Regardless of whether a QIO overturns an Adverse organization determination, plans are to report the initial adverse or partially favorable organization determination.
18.	Should cases forwarded to the Part C IRE be counted once in the reporting section, i.e., as the Partially Favorable or adverse decision prior to sending to the IRE?	When a plan upholds its adverse or partially favorable organization determination at the reconsideration level, the plan generally must report both the adverse or partially favorable organization determination *and* reconsideration. Exceptions: Plans are not to report QIO determinations concerning an inpatient hospital, skilled nursing facility, home health and comprehensive outpatient rehabilitation facility services terminations.
19.	Should supplemental benefit data be excluded from the Part C Reporting?	As described in this guidance, a plan's response to a request for coverage (payment or provision) of an item or service is a reportable organization determination. Thus, requests for

		coverage of a supplemental benefit (e.g., a non-Medicare covered item/service) are reportable under this effort.